

SLEEP STUDY REFERRAL FORM

Sterling Medical Park
DENT Neurologic Institute
200 Sterling Drive
Orchard Park, NY 14127



DENT
SLEEP DISORDERS CENTER

DENT Tower – *Open April 2005*
DENT Neurologic Institute
3980 Sheridan Drive
Amherst, NY 14226

Phone: (716) 250 – 7007 Fax: (716) 674 – 4196

GENERAL PATIENT INFORMATION

Date of Request ___/___/___ DOB ___/___/___ Age: _____
Patient Name _____ Gender: Male Female
Patient SS# _____ Shift Patient Works: 1st 2nd 3rd
Address: _____

Home Phone #: _____ Work #: _____ **PATIENT INSURANCE INFORMATION**
Primary Plan _____ Policy ID# _____
Secondary _____ Policy ID# _____

ORDERING PHYSICIAN CONTACT INFORMATION

Referring Physician: _____
Phone Number: _____ Fax: _____
For results, would you prefer: Call from Doctor Faxed Report ASAP/Hard Copy

REQUEST FOR STUDY / PATIENT HISTORY

**NOTE: The following medical information is necessary prior to initiating this sleep study.
Please complete and fax to the Sleep Disorders Center at 716-674-4196. Thank you.**

Would you prefer a sleep consult prior to sleep study? YES NO

SLEEP CENTER TESTING: Polysomnogram Split Night (PSG/CPAP)
 CPAP Titration PSG/Multiple Sleep Latency Test

Additional Monitoring: Full EEG Monitoring Additional Limb Monitoring Video

Symptoms: Sleepiness Insomnia Snoring Witnessed Apnea Abnormal Behaviors
 Headaches Other _____

PMH: HTN CVA Heart Disease Peripheral Neuropathy Diabetes
 COPD Back Injury Headaches Other _____

Current Medications: _____

Allergies: _____

Special Needs: _____

Is the patient on O²? Yes No If yes, start study with ___ or without ___ O²?

Can CPAP/BiPAP therapy be initiated on an emergency basis? Yes No

Patient's Preferred Study Location: First Available Orchard Park, NY Amherst, NY – *Open April 2005*

SLEEP STUDY INFORMATION

To Be Completed by DENT Sleep Disorders Center

Test Date: ___/___/___ **Test Time:** ___:___ AM/PM **Initials:** _____

Information Packet Mailed: Yes **Date Mailed:** ___/___/___